



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF NUTRITION SERVICES AND WIC
WIC CERTIFICATION - INFANT/CHILD

Persons with disabilities who require alternative means for communication of program information (Braille, large print, audiotape, etc.) may contact the Missouri Department of Health and Senior Services, Bureau of Nutrition Services and WIC, phone 1-800-392-8209. TDD users can access the previous phone number by calling 1-800-735-2966. An equal opportunity provider and employer.

AGENCY												<input type="checkbox"/> ADDITION <input type="checkbox"/> RECERT																							
INFANT/CHILD																																			
DCN						LAST NAME						SUFFIX						FIRST						MIDDLE											
RACE 1 - WHITE 2 - BLACK/AFRICAN AMER. 4 - AM. IND./ALASKAN 5 - ASIAN 6 - NATIVE HAW/PAC ISL U - UNABLE TO DETERMINE						ETHN HISP Y N U		SEX M F		BIRTHDATE						AGE		SOCIAL SECURITY NUMBER																	
PARENT/GUARDIAN(S)																																			
DCN						LAST NAME						SUFFIX						FIRST						MIDDLE						MAIDEN					
RACE 1 - WHITE 2 - BLACK/AFRICAN AMER. 4 - AM. IND./ALASKAN 5 - ASIAN 6 - NATIVE HAW/PAC ISL U - UNABLE TO DETERMINE						ETHN HISP Y N U		SEX M F		BIRTHDATE						AGE		SOCIAL SECURITY NUMBER																	
COMMON DATA SYSTEM ID 02																																			
H201 ADD H202 UPDATE						MEDICAID Y N U				MEDICAID CASE MANAGED Y N U				FOOD STAMPS Y N U				FOSTER CARE Y N U				TANF Y N U													
STREET ADDRESS										CITY										STATE MO		ZIP CODE													
PHONE ()				MESSAGE PHONE ()				MOTHER/FEMALE GUARDIAN EDUCATION LEVEL B G (BIOLOGICAL/GUARDIAN)												COUNTY OF RESIDENCE															
HEALTH HISTORY																																			
H224 ADD H225 UPDATE						AT BIRTH CROWN-HEEL LENGTH /8(IN) /10(CM)						AT BIRTH WEIGHT (LBS/OZ) (GMS)						IMMUNIZATIONS REVIEWED 0 1 2 3 4																	
UPDATE UNTIL 24 MONTHS OF AGE (ADDS AND RECERTIFICATIONS)																																			
FEEDING DATA																																			
IS INFANT CURRENTLY BEING BREASTFED? Y N IF YES, FULLY OR PARTIALLY? F P WAS INFANT EVER BREASTFED? Y N IF YES, HOW LONG (M) MONTHS (W) WEEKS AGE REC'D FORMULA/MILK AS A REGULAR NUTRITION SOURCE? (WKS.): 0 (NEVER) (WEEKS) 1 2 3 4 5 6 7 8 (≥8) 9 (UNKNOWN)																																			
WIC ELIGIBILITY CLIENT DATA																																			
H421 ADD H422 RECERT/REASSESS H427 INQUIRY		CAPE SITE		PROG. I C		MIGRANT M		SPECIAL STATUS H T O		DATE SERV. REQ.		TYPE OF CONTACT T W		FAM. SIZE		FAMILY INCOME W M A \$				FIN. ELG. Y N A X															
		SEEING PHY. Y N		DIET ASSESS. Y N		LEAD TEST Y N		HEALTH ASSESSMENT DATE						HEIGHT/LENGTH /8(IN) /10(CM)																					
		WEIGHT FOR CHILD /4(LBS) /10(KG)				WEIGHT FOR INFANT (LB/OZ) (GMS)				HEAD CIRCUMFERENCE /8(IN) /10(CM)																									
		HEMATOCRIT /10		HEMOGLOBIN /10		BLOODWORK DATE		ORAL ASST. Y N		MED. ELIG. Y C M		RISK FACTORS				PRIORITY		FOOD PKG.		SEQ. 1 2															
		SERVICE DATE		RECERT. DATE								BMI		CPA INITIAL		NEW FPC		NEW SEQ		NEW CYCLE															
		REFER TO IMMUN (CIRCLE): CHILD ABUSE		PHY COM BASED		DNTL HLTH OTHER		HCY NO REFERRAL		TANF		FD STAMPS		MCAID		HD START		SHCN		LEAD															
SIGNATURE (INCOME ASSESSMENT)												TITLE												DATE											
SIGNATURE - CPA (RISK ASSESSMENT)												TITLE												DATE											
PARTICIPANT'S RIGHTS AND RESPONSIBILITIES																																			
READ BY OR READ TO THE PARTICIPANT'S PARENT/GUARDIAN AT THE TIME OF CERTIFICATION.																																			
1. VERIFICATION OF INCOME IS DETERMINED BASED ON INFORMATION REPORTED BY YOU AND ASSESSED ACCORDING TO CURRENT INCOME GUIDELINES PROVIDED BY THE STATE AGENCY.																																			
2. STANDARDS FOR ELIGIBILITY AND PARTICIPATION IN THE WIC PROGRAM ARE THE SAME FOR EVERYONE REGARDLESS OF RACE, COLOR, NATIONAL ORIGIN, AGE OR DISABILITY.																																			
3. YOU HAVE THE OPPORTUNITY TO APPEAL ANY DECISION MADE BY THIS LOCAL AGENCY REGARDING YOUR ELIGIBILITY FOR THE WIC PROGRAM.																																			
4. THIS LOCAL AGENCY WILL MAKE HEALTH SERVICES AVAILABLE TO WIC PROGRAM PARTICIPANTS .YOU ARE ENCOURAGED TO PARTICIPATE IN THESE HEALTH SERVICES.																																			
5. YOU MUST NOTIFY THIS LOCAL AGENCY BEFORE MOVING TO MAINTAIN UNINTERRUPTED PROGRAM BENEFITS.																																			
THIS CERTIFICATION IS BEING MADE IN CONNECTION WITH THE RECEIPT OF FEDERAL FUNDS. PROGRAM OFFICIALS MAY VERIFY INFORMATION ON THIS FORM. INTENTIONALLY MAKING A FALSE OR MISLEADING STATEMENT OR INTENTIONALLY MISREPRESENTING, CONCEALING OR WITHHOLDING FACTS MAY RESULT IN PAYING THE STATE AGENCY, IN CASH, THE VALUE OF THE FOOD BENEFITS IMPROPERLY ISSUED AND MAY SUBJECT YOU TO CIVIL OR CRIMINAL PROSECUTION UNDER STATE AND FEDERAL LAW.																																			
I HAVE BEEN ADVISED OF MY RIGHTS AND OBLIGATIONS UNDER THE WIC PROGRAM. I CERTIFY THAT THE INFORMATION I HAVE PROVIDED FOR MY ELIGIBILITY DETERMINATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.																																			
I consent to the release of necessary and required program information on myself and/or my children to the Food and Nutrition Services administered by United States Department of Agriculture; Maternal and Child Health Programs (Dental Health, Children with Special Health Care Needs, Immunization, and Family Planning programs) administered by Missouri Department of Health and Senior Services; Headstart, Migrant Education Programs administered by Missouri Department of Elementary and Secondary Education; and Medicaid administered by Missouri Department of Social Services for the purpose of determining eligibility, program coordination and conducting outreach activities.																																			
DATE						SIGNATURE OF PARENT/GUARDIAN																													